



SD NDBEDP Program

National Deaf-Blind Equipment Distribution Program
South Dakota Department of Human Services

Application Section 1 of 3: Instructions and Guidelines

Overview

The National Deaf-Blind Equipment Distribution Program (NDBEDP) will ensure that low-income individuals who have combined hearing and vision loss can access telephone, advanced communications and information services. This program was mandated by the Twenty-First Century Communications and Video Accessibility Act of 2010 (CVAA), which authorizes the Federal Communications Commission (FCC) to provide funding for local programs to distribute equipment to low-income individuals who are deaf-blind (who have hearing loss and vision loss). For more information on the National Deaf-Blind Equipment Distribution Program (NDBEDP), please visit: <http://www.icanconnect.org>

Who is eligible to receive equipment?

Under the CVAA, only low-income individuals who are deaf-blind are eligible to receive equipment. Applicants must provide verification of their status as low-income and deaf-blind. The FCC defines "low income" to mean not more than 400% of the Federal Poverty Guidelines.

Income eligibility

To be eligible for iCanConnect, your household income must be below 400% of the Federal poverty level, as shown in the following table:

2012 Federal Poverty Guidelines			
Number of persons in family/household	400% for everywhere, except Alaska and Hawaii	400% for Alaska	400% for Hawaii
1	\$44,680	\$55,880	\$51,440
2	\$60,520	\$75,680	\$69,640
3	\$76,360	\$95,480	\$87,840
4	\$92,200	\$115,280	\$106,040
5	\$108,040	\$135,080	\$124,240
6	\$123,880	\$154,880	\$142,440
7	\$139,720	\$174,680	\$160,640
8	\$155,560	\$194,480	\$178,840
For each additional person, add	\$15,840	\$19,800	\$18,200
Source: <u>U.S. Department of Health and Human Services</u>			

For purposes of determining income eligibility for NDBEDP, the FCC defines “income” and “household” as follows:

“Income” is all income actually received by all members of a household. This includes salary before deductions for taxes, public assistance benefits, social security payments, pensions, unemployment compensation, veteran's benefits, inheritances, alimony, child support payments, worker's compensation benefits, gifts, lottery winnings, and the like. The only exceptions are student financial aid, military housing and cost-of-living allowances, irregular income from occasional small jobs such as baby-sitting or lawn mowing, and the like.

A “household” is any individual or group of individuals who are living together at the same address as one economic unit. A household may include related and unrelated persons. An “economic unit” consists of all adult individuals contributing to and sharing in the income and expenses of a household. An adult is any person eighteen years or older. If an adult has no or minimal income, and lives with someone who provides financial support to him/her, both people shall be considered part of the same household. Children under the age of eighteen living with their parents or guardians are considered to be part of the same household as their parents or guardians.

See Section 2 for the household income information that must be provided with this application.

Disability eligibility

For this program, the CVAA requires that the term "deaf-blind" has the same meaning given by the FCC. In general, the individual must have a certain vision loss and a hearing loss that, combined, cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation (working).

Specifically, the FCC’s NDBEDP rule 64.610(c)(2) states that an individual who is “deaf-blind” is:

(i) Any person:

(A) Who has a central visual acuity of 20/200 or less in the better eye with corrective lenses, or a field defect such that the peripheral diameter of visual field subtends an angular distance no greater than 20 degrees, or a progressive visual loss having a prognosis leading to one or both these conditions;

(B) Who has a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification, or a progressive hearing loss having a prognosis leading to this condition; and

(C) For whom the combination of impairments described in clauses (c)(2)(i)(A) and (B) of this section cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining a vocation.

(ii) The definition in this paragraph also includes any individual who, despite the inability to be measured accurately for hearing and vision loss due to cognitive or behavioral constraints, or both, can be determined through functional and performance assessment to have severe hearing and visual disabilities that cause extreme difficulty in attaining independence in daily life activities, achieving psychosocial adjustment, or obtaining vocational objectives. An applicant's functional abilities with respect to using telecommunications, Internet access, and advanced communications services in various environments shall be considered when determining whether the individual is deaf-blind under clauses (c)(2)(i)(B) and (C) of this section.

Who can attest to a person's disability eligibility?

A practicing professional who has direct knowledge of the person's vision and hearing loss, such as:

Audiologist	School for the deaf and/or blind
Community-based service provider	Specialist in Deaf-Blindness
Educator	Speech pathologist
Hearing professional	State equipment/assistive technology program
HKNC National Deaf-Blind representative	Vision professional
Medical/health professional	Vocational rehabilitation counsellor

See Section 3 for the disability attestation information that must be provided with this application.

Confidentiality policy

Department of Human Services is committed to ensuring that your privacy is protected. Information provided on this application form will only be used to determine eligibility for products and services. Department of Human Services will not sell, distribute or lease your personal information to third parties unless you give permission, or if the NDBEDP program is required by law to do so. Department of Human Services is committed to ensuring that personal information is secure. In order to prevent unauthorized access or disclosure, suitable physical, electronic and managerial procedures are in place to safeguard and secure the information the NDBEDP program collects.



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Application Section 2 of 3: Applicant's Personal Data

(Please fill in all fields)

Name: _____

Address: _____

Phone: _____ Voice _____ TTY _____ VP _____

Cell Phone: _____ **Email:** _____

Communication Preference: _____ TTY _____ VP _____ CapTel _____ Cell Phone _____ TRS
_____ VRS _____ Email _____ Fax

Alternate Contact (*in case of emergency*): _____

Address: _____

Phone: _____ **Cell Phone:** _____ **Email:** _____

Alternate Contact's Communication Preference: _____ TTY _____ VP _____ CapTel
_____ Cell Phone _____ TRS _____ VRS _____ Email _____ Fax

Date of birth: _____ **Gender:** _____

Language preference: _____

State in which you are a permanent resident? _____

Are you over 18 years of age? Yes/No (*If no, your legal guardian must sign the application.*)

Feedback/suggestions (optional): _____

How did you hear about this program?

- | | |
|--|--|
| <input type="checkbox"/> iCanConnect.org website | <input type="checkbox"/> Media/news |
| <input type="checkbox"/> Conference or seminar | <input type="checkbox"/> Medical provider |
| <input type="checkbox"/> Disability advocacy group | <input type="checkbox"/> Senior Center |
| <input type="checkbox"/> Education provider/school | <input type="checkbox"/> Specialist in Deaf-Blind Services |
| <input type="checkbox"/> Family member | <input type="checkbox"/> State Deaf-Blind Project |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Technology vendor |
| <input type="checkbox"/> Healthcare provider | <input type="checkbox"/> Vocational Rehabilitation Counselor |
| <input type="checkbox"/> Helen Keller National Center (HKNC) | <input type="checkbox"/> Other professional |
| <input type="checkbox"/> HKNC rep | <input type="checkbox"/> Other - general |
| <input type="checkbox"/> Independent Living Center | <input type="checkbox"/> Department of Human Services |
| <input type="checkbox"/> Interpreter | <input type="checkbox"/> Website |

Income eligibility

To confirm your income eligibility, please mail or fax a copy of last year's Federal 1040 IRS tax form, or send documentation that proves your eligibility for one of the following federal low-income programs:

- ☐ Medicaid
- ☐ Low income home energy assistance
- ☐ SSI
- ☐ Federal public housing assistance or Section 8
- ☐ Food Stamps or SNAP (Supplement Nutrition Assistance Program)
- ☐ Temporary Assistance for Needy Families (TANF) or Welfare to Work (WTW)
- ☐ If none of the above apply, last year's Social Security Administration benefit statement or other pension benefit statement

With my signature below I hereby request services and certify that:

- 1) the information I have provided in this application is true and accurate to the best of my knowledge;
- 2) the benefit document(s) submitted represent the entire income for my household; and
- 3) I authorize the confidential release of the disability and income information I have provided, for use solely as required for the administration of my application to the NDBEDP Program.

I acknowledge that I am subject to audit and if I am found providing inaccurate information on this form, I will be prosecuted to the fullest extent allowable by law. Should I become eligible for services, I agree to use these services solely for the purposes intended. I further understand that I may not sell, mortgage, lend or transfer interest in any equipment or services provided to me. Falsification of any records or failure to comply with these provisions will result in the immediate termination of service.

Name of applicant (print): _____

Signature of applicant/guardian: _____ **Date:** _____



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Application Section 3 of 3: Disability Verification

This disability verification section is to be completed by a practicing professional who has direct knowledge of the applicant's vision and hearing loss.

Please complete the following fields, and sign and date at the bottom.

Name and Address of Deaf-Blind Individual (Applicant):

Name: _____

Street address: _____ **City/state/zip:** _____

Attester:

Name: _____ **Title:** _____

Agency: _____

E-mail: _____ **Phone:** _____

Street address: _____ **City/state/zip:** _____

I certify under penalty of the law that this individual is deaf-blind as defined above by the FCC.

Signature: _____ **Date:** _____

Fax, e-mail, or mail completed application (Sections 1, 2 and 3) to:

Janet Ball
Department of Human Services
Hillsview Properties Plaza
3800 E Hwy 34, c/o 500 E Capitol
Pierre, SD 57501

E-mail: janet.ball@state.sd.us Fax: 605-773-5483 Telephone inquiries: 605-773-5990

If scanned documents are submitted, please use PDF format
(This document is available upon request in hard copy print and electronic text)